HHA PPS MAILBOX QUESTIONS
VOLUME VI: June 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *"e-mailto:HHPPS@HCFA.gov"* during the period referenced above. It is our intention to continue to answer questions that come into that mailbox in monthly batches, and post those answers at: *"http://www.hcfa.gov/medlearn/refhha.htm"*. This batch of questions was pulled from the mailbox prior July 1, 2001. In cases where time is needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

Questions by Major Topic

Alphabetical Cross-reference Topics

Partial Episode Payment (PEP) Adjustments: 4
Pricer software: 11
Requests for Anticipated Payment (RAP): 2, 4, 6, 12
Revenue Codes: 5
Significant Change in Condition (SCIC) Payment: 2, 3, 4, 5
Source of Admission code: 4
Therapy Threshold: 2
Type of Bill (TOB): 8

General Terms/Acronyms

The following terms/acronyms may not be spelled out/explained above or elsewhere in this document:

CMS = The Centers for Medicare and Medicaid Services, new name of HCFA (below).

Case Mix = Characteristics of a patient affecting cost of treatment; for HH PPS, these include the patient's clinical and functional condition, as well as related service demands.

HH = Home Health

HHA = Home Health Agency

HCFA = Health Care Financing Administration, previous name of the federal agency administering Medicare and Medicaid. Note: The name of the agency was changed to CMS (above).

HCPCS = HCFA Common Procedure Coding System, individual codes representing medical services or items in Form Locator 44 of Medicare claims

HHRG = Home Health Resource Group, the payment group for HH PPS episodes

HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare institutional claim, placed in Form Locator 44

MSA = Metropolitan Statistical Area, a series of codes representing geographic locations put on Medicare HH claims so that payment is commensurate with the location in which services are delivered.

OASIS = Outcome and Assessment Information Set. The standard assessment instrument required by CMS for use in delivering home care.

PPS = Prospective Payment System. A pre-determined method of fee for service payment of bundled services, as opposed to cost reimbursement of individual services, used to pay many types of Medicare providers (hospitals, SNFs, etc.); Medicare pays for home care under a plan of care through a PPS since October 1, 2000.

RAP = Request for Anticipated Payment. The first of two transactions submitted on a UB92 claim form to get the first of two split percentage payments for a HH PPS episode.

RHHI = Regional Home Health Intermediary. Medicare fiscal intermediary specializing in the processing of hospice and home health claims.

SNF = Skilled Nursing Facility.

CONSOLIDATED BILLING

Q1: A patient who was recently discharged by a home health agency was prescribed and is seeking outpatient physical therapy. The patient would be admitted within 60 days of the HH start of care. Can the outpatient rehab facility bill Medicare directly for services if the HHA has "closed" the episode by discharging or is the HHA responsible for providing the care?

A1: The outpatient rehab facility can bill Medicare directly if the final claim for the episode of care has been received from the HHA. The HHA is not responsible for therapy services received by the beneficiary after the beneficiary has been discharged. Currently, it is possible that if a beneficiary has been discharged from home care and the home health agency has not yet billed their discharge claim for the home health episode, a therapy claim will be rejected inappropriately. In this case, the claim is rejected and not denied and can be resubmitted for payment after the home health claim has been received. Medicare systems are being corrected in October 2001 to prevent these therapy claims from being rejected. The corrections are described in Program Memorandum AB-01-70, dated May 1, 2001. Program Memoranda are available on our website at: http://www.hcfa.gov/pubforms/progman.htm.

RATES and PAYMENT

Q2: If at the time of the RAP was submitted reaching the therapy threshold was not anticipated, but in practice it was necessary to do significant therapy, will the intermediary adjust final claim payment upward in recognition of the extensive therapy, or do we have to cancel and resubmit the RAP?

A2: You need to cancel the RAP and resubmit it with the corrected HIPPS code that reflects a revised therapy projection. [Revised September 18, 2001.]

Q3: Please provide clear-cut directions on reporting of a SCIC. When does an agency need to report the SCIC-and how does it affect the reimbursement?

A3: SCICs are to be reported in all cases in which multiple HIPPS codes result from OASIS assessments and changes in physician orders in the course of an episode, with two exceptions. The first exception is when the HIPPS code changes in a manner that does not change the payment group that applies to the episode. That is, no change in the HIPPS, or just a change to the fifth position of the HIPPS code, does not require a SCIC to be reported. The second exception is when the SCIC calculation indicates that payment for the episode would decrease as a result of reporting the SCIC and the HIPPS code weight increased (i.e., the beneficiary's condition worsened). A SCIC must be reported in all other cases, including cases in which the beneficiary's condition improves in a manner unanticipated by the

original plan of care. SCICs affect reimbursement by prorating the payment for the episode on a basis of days of service provided under each HIPPS code.

Q4: We admitted a new patient who was on service for 30 days and discharged. This same patient was referred back to home health 10 days later, which would actually be day 40 of the previous 60-day period. If the final bill has not been sent, is the agency to consider this a SCIC? Does this mean that a Start of Care OASIS is not done on Day 40 for the re-admission, but instead the agency is to do a follow-up form for a SCIC?

A4: In this case, the earlier period of services (the first 30 days) should be submitted as a final claim for the episode. Since you are aware of the readmission within the original 60-day episode you should submit this claim with patient status 06. This claim would be paid a partial episode payment (PEP). When a patient is discharged from the HHA but is re-admitted before the end of the original 60-day episode, the HHA would receive a payment that is proportionate to the number of days of care delivered divided by 60-- a PEP adjustment. In this case, the payment for the first admission to the HHA would be 30 divided by 60 or ½ the full payment for that episode.

When the patient is re-admitted on the 40th day, a new episode of care begins, and a new OASIS start of care assessment is completed. This would be Day 1 of a new 60-day episode. For billing, you would submit a RAP with a "from" date indicating the date of the first visit after the readmission. Be sure to use source of admission code "C" on this RAP, which indicates a discharge and readmission within the original episode period.

NOTE: This response corrects an answer originally posted in response to a similar question received in January (Volume 1, Batch 3, question 5). That answer has also been revised in this posting.

Q5: We have received an error code 31755 on a final bill. This bill was a SCIC. The initial 0023 revenue code line was dated the same as the first visit, but the 0023 revenue code line for the SCIC did not have a corresponding billable service date. Is this what caused the claim to receive the error? Does a resumption of care have to have a corresponding billable date of service?

A5: The line item date on any 0023 revenue code line must correspond to a visit date on the claim. This reflects the payment policy that SCICs are calculated based on the number of days between the first and last billable visit provided under each HIPPS code. Since the payment for an additional HIPPS codes is not effective until the first billable visit provided after the change in condition is identified, the visit date must be reported in association with the HIPPS code.

The visit made to perform a resumption of care assessment may be, but is not required to be, a visit in which billable services are also provided. If the assessment visit is a billable visit, this visit date should be reported on the 0023 revenue code

line. If it is not a billable visit, the date of the next billable visit should be reported on the 0023 revenue code line.

EPISODE ADMISSION AND DISCHARGE

Q6. A patient is admitted on November 28 and is covered by a Medicare managed care HMO product. The agency did an OASIS at time of admission. On January 4, the agency was notified that the patient was no longer covered by the managed care product, but had chosen to return to traditional Medicare coverage. How does the agency bill this PPS episode, and what HIPPS code is used, if there was no OASIS done within the 5-day period?

A6. You are aware that if there is a change of payer, even from Medicare managed care to Medicare fee for service, a new OASIS assessment must be done. Under a recent refinement to Medicare policy, if an assessment is not done within the episode period, for any reason including misinformation on the current payer, an assessment should be done as soon as possible. This assessment should reflect the patient status at the most recent of: discharge, the end of the episode, or the patient's current condition. To the greatest degree possible, the OASIS should assess an actual or current patient, not a reconstruction of a patient from memory. For this reason, it is important to check repeatedly with the patient or his/her representative about insurance coverage during the episode.

In cases such as that described above, an OASIS assessment should be done immediately upon notification, using the new start of care date. The HIPPS code produced by this assessment is used to bill the entire episode, which will start on the same date as the first service under Medicare fee for service. OASIS timing warnings may be received when such assessments are transmitted, but will not prevent transmission. RAPs and claims may be submitted for the entire timely filing period.

Q7. Has CMS (HCFA) developed a uniform definition for the discharge date? Currently on my final episode claims, I use the last visit date if the patient has been discharged. Is this correct?

A7. Your question focuses on closing episodes for billing purposes. Though there was initially a contradictory HH PPS policy (discarded at the start of the system), you are not limited to using the last billable service date as the through date (FL 6 of the UB-92 claim form) or discharge date on the claim. You may use the date you discharge the patient, even if you did not perform a service on this date, as long as the day is within the episode period. However, if you will be continuing care into the next episode period, the through date of your claim should be the 59th day after and not including the date the episode started.

CLAIMS, ELEMENTS AND CODING

Q8. We have a patient that, in the middle of the episode, became ineligible for Medicare benefits because he was no longer homebound. We completed the HHABN and the patient picked option A. I understand that the Demand Bill (condition code 20) must be sent in on a Type of Bill (TOB) 329.

Questions: (1) Is that correct? Do we have to wait until the end of the episode to request the denial?
(2) The patient became self-pay on 6/22/01, and start of care was 5/22/01. How do we show this information on the claim?

A8. Yes, it is correct that under current instructions for HH PPS demand billing (found at Section 3638.30 in the Medicare Fiscal Intermediary Manual), you must wait until the end of the episode to bill the claim. You must also use TOB 329. Medicare is currently examining if the period for demand billing can be shortened; however, this is likely to be limited to situations where the beneficiary is ineligible for Medicare home care from the very beginning of the episode.

Relative to the second part of your question, your billing would show the episode starting on May 22. You would bill services you believe are covered as covered charges on the claim, which in this example would seem to be services delivered on and before June 21. You would bill services you believe are not covered with non-covered charges in FL 48 of the claim for the period from June 22 to the end of the episode. This procedure is covered in the current demand billing instructions referenced above.

Q9. Is there a list of HCPCS codes somewhere, just for drugs, that is kept current?

A9. There is no subset list related to subject matter like drugs. HCPCS Level 1 codes are the same as CPT-4 codes copyrighted by the AMA. To obtain a list of these codes, contact the AMA at: 1-800-621-8335.

HCPCS Level 2 can be found on the CMS (formerly HCFA) website: http://www.hcfa.gov/stats/pufiles.htm. At the bottom of this page is a description of HCPCS Level 2 coding and links to download several years of annual HCPCS codes, including those for 2001. For more direct access, you may also try:

http://www.hcfa.gov/stats/pufiles.htm#alphanu.

HCPCS codes generally describe medical procedures and devices. There is a category of HCPCS for "drugs other than chemotherapy", Codes J0000-J8499, most of which are given as injections. There may also be some codes in the lists starting with other letters, such as A, C, K or Q that describe medications. Note that Medicare does not currently cover most prescriptions for medications physician give directly to patients, hence the current debate in Congress about adding a prescription drug benefit.

Q10. Where can I find a current list of HHRG amounts by MSA code?

Q11. Please give us a web address where we can go to find out our MSA code that is required on the UB-92 claim forms. Where do we find this information?

A10 and 11. HHRGs are represented by HIPPS codes on HH PPS claims. Since there are hundreds of HIPPS and thousands of MSAs, most billing vendors have built the calculation HIPPS payment by MSA into billing software according to their clients' needs. CMS [HCFA] has not posted this information on our website given the size of such tables if every value were to be calculated out, nor do we expect all these calculations to be found on the websites of our RHHIs. Many of these calculations occur in HH PPS Pricer software. This software can be downloaded from the CMS web site at the following URL:

www.hcfa.gov./medicare/nm75ght/priceint.htm.

A table of HIPPS codes and weights can be found at our website at www.hcfa.gov/medlearn/refhha.htm. Note that toward the bottom of this page, there is a header for the "Home Health Payment System Training Session", and the tables are listed under this header.

The weight for the applicable HIPPS code is multiplied by the applicable national standard episode amount. The amount is $2,274.17 for non-rural and $2,501.59 for rural areas for FY 2002 (the government fiscal year starting October 1, 2001). This product of this multiplication is then split according to ratios for the labor and non-labor portion of the payment. The total product should be multiplied by.77668 to produce the labor portion, and that same total by .22332 to produce the non-labor portion of the episode.

The labor portion alone is further multiplied by the MSA wage index for the area in which the service is delivered—for home care, the beneficiary's home. A table of MSAs can be found in the HH PPS Final Rule, Section IV. B. 4., Hospital Wage Index; however, corrections to this list must also be consulted. Note rural areas are represented by MSA codes beginning with "99". Both the correction list and the Final Rule providing MSAs, as well as an update notice with FY 2002 wage indices, can be found at the website address or URL given above.

The product of the labor portion multiplied by the MSA wage index is then added back to the non-labor portion to produce the total possible episode payment for a given HIPPS in a given MSA. It should be noted, however, that payment may change further if payment adjustments like PEPs or outliers apply to specific episodes. [*See also a similar answer, reflecting earlier rate periods, in Volume 2, Batch 1, question 1* .]

Q12. The individual that performs our OASIS entry and validation checks has been told by our corporate parent that a HIPPS code ending in "2" will generate a billing error

when that file is submitted to our intermediary. I understand from my research that a HIPPS code of 2 will not prevent the record from being locked by the state and does not indicate a fatal error. I have reviewed the record in question extensively to determine if the clinician made an error in completing her OASIS, but failed to find any. What types of error(s) would cause a 5th digit of "2" to be reported when the HIPPS code is calculated by the grouper software? Would this relate to any specific M0 questions?

A12. Section 467.13 of the Medicare Home Agency Health Manual contains a table that explains all of the five digits composing HIPPS codes for Medicare home health billing, and crosswalks these codes to HHRG payment groups. Though HIPPS codes are used on claims, software supporting OASIS data entry actually outputs HH HIPPS codes.

Grouping Software Outputting HIPPS. If an agency is using HAVEN software released by CMS [HCFA] to support OASIS, HAVEN will return a "1" or "2" in the 5th digit of the HIPPS code when all information is completed as required. (If not, HAVEN will alert the user to make the appropriate corrections). A "1" means that the relevant OASIS data were all valid for computing the HIPPS code. A "2" indicates something amiss with the diagnosis coding in M0230/240. This could happen if HHAs try to use a manifestation code in the primary diagnosis field, or if all 4 or 5 digits required for certain diagnoses codes in the case mix diagnosis groups are not used. Anything other than a "1" or a "2" in the accuracy position will be rejected by State OASIS systems. This is not because of the HIPPS code per se, but because any error that would cause the fifth digit of the HIPPS code to be 3-8 would cause the record to fail at least one fatal error check. This won't happen to HAVEN users, since HAVEN won't allow the record to be locked until the error is corrected.

Other vendor software might not operate exactly as HAVEN does. The OASIS data specifications do not include exactly the same diagnosis validity checks that the grouper application does (the grouper application is incorporated into HAVEN), because OASIS diagnosis coding requirements are more lenient than payment-related requirements, in certain instances.

Diagnosis Coding. None of the instances that result in a HIPPS code with a fifth digit of 1 or 2 being output are the basis for an OASIS edit-check, because there is nothing wrong with the data in the eyes of the OASIS. However, it could mean that the HHA is not receiving accurate payment through correct diagnosis coding. The HH PPS Final Rule specified that certain payment-related diagnosis codes which should never be used as primary diagnosis must be coded to the complete level of detail, and placed in the first secondary position, or else they cannot earn case mix points towards determining the payment group. (In this scenario, the primary diagnosis is actually indicated by two codes--one for the underlying condition, placed in the primary field, and the other for the manifestation of that condition, placed in the initial secondary diagnosis field. The manifestation codes are printed in italics in the tabular list of the ICD-9 manual. Coding to the complete level of detail means using four or five digits, depending on the specific requirements of

ICD-9.) Other codes from the same diagnosis families that could properly be reported in the primary diagnosis field also have to be coded to the complete level of detail.

The above rules are implemented in the case mix grouper logic. If the software finds that the necessary detail is missing, or that a detailed code is erroneously in the primary diagnosis field, the data are considered invalid. Invalid data cannot earn points for case mix. The HIPPS code fifth position serves as a flag, or warning, that invalid data were found. If the data were corrected, it's possible that additional points would be granted to the case. With additional points, the case mix group might change (but not always). Therefore, agencies are correct in being concerned that anything other than a 1 in the HIPPS fifth position could mean they are not getting the full payment to which the case is entitled. As long as the agency is using the official grouper, or uses other software that was developed in accordance with the official grouper logic, it can benefit from the warning system. CMS expects all grouper software, no matter what its origin, to follow the official grouper logic specifications.

Billing. Your intermediary will accept HIPPS codes ending with the digit "2" on claims. The only specification for HIPPS codes on claims is that the HIPPS for an OASIS assessment and the RAP or claim it supports must match. Therefore, as long as your state agency accepts transmission of the HIPPS code you are outputting, you can use that same code for billing no matter what the final digit.

DIAGNOSIS CODING

Q13: According to ICD-9 guidelines traumatic wounds 870-897 are considered "open wounds" defined as lacerations, puncture wounds, cuts, animal bites, avulsions and traumatic amputations that are amputations that are not associated with internal injury dislocation, fracture or intracranial injury. This would lead me to believe that a surgical wound is not a trauma wound and that the home care nurse should be documenting the primary home care diagnosis as the reason for the surgery? If a patient suffers a fracture due to a fall- in what category should this fall-trauma according to ICD-9 guidelines? Can you help with the above clarification.

A13: This question has two distinct parts. The following response will be divided to cover each specific aspect of the question.

Part A of Question: Correct documentation of a surgical wound by a Medicare Certified Home Health Agency. A surgical wound is not a trauma wound per ICD-9-CM guidelines. When a patient is admitted to home care primarily for surgical wound assessment and treatment, the condition responsible for the surgery must be documented. V-codes would be the most appropriate codes to use in many post-surgical wound cases, according to ICD-9-CM coding guidelines however currently, OASIS does not allow V-codes. Rather than using V-codes, the OASIS instructions indicate the agency should code the primary diagnosis from the condition

responsible for the surgery. This raises a problem for diagnosis coding in many post-surgical wound care cases. If the agency selects a code for the condition that led to the surgical wound, the result may be a diagnosis that the patient no longer has. Nevertheless, in many if not most post-operative admissions to home health, when a patient is admitted to home care mainly for surgical wound assessment and treatment, the condition responsible for the surgery must be used as the primary diagnosis.

Part B of Question: If a patient suffers a fracture due to a fall-in what category should this fall-trauma according to ICD-9-CM guidelines? A fracture due to a fall is assigned a diagnosis from the chapter on injuries and poisonings (i.e., traumatic fracture codes). Occasionally a symptom code from Chapter 16 can be used instead of the fracture-for example, when the post-surgical fracture patient is primarily receiving physical and occupational therapy for mobility restoration, a symptom code that directly describes the mobility problem being addressed avoids reporting a problem treated in the hospital (the fracture).

Q14. We are continuing to have a problem with the use of trauma codes. If we provide wound care for a patient that had a colon resection due to cancer and gangrene, would the open wound be our primary diagnosis? Wound care and observation for infection constitute medical necessity for the involved nursing visits. However, we believe the ICD-9 Manual describes this as a trauma code. In the Volume 1: Batch 2 answers to questions sent to this mailbox *[still posted at this site]*, you stated coders should list the underlying medical relevant diagnosis. Then in another case with a patient with a BKA, you said to list the open wound as the primary diagnosis, instead of the underlying disease of diabetes. Can you please clarify which primary diagnosis is correct?

A14. This is also a two-part question, therefore the specific response will be written following each part of the question.

Part A of the question: We are continuing to have a problem with the use of trauma codes. If the primary reason for home care is an infected surgical wound, the code for an infected surgical wound is appropriate as the primary diagnosis. The code for an infected surgical wound is located in the "Injury and Poisoning" section of the ICD-9-CM under "Complications of Surgical and Medical Care, Not Elsewhere Classified" (996-999). The codes for complication s of medical and surgical care should only be reported when a complication has been documented by the patient's physician. If not, then you are obliged to code what OASIS calls the "relevant medical diagnosis" or underlying diagnosis". The October 2, 2000, Program Memorandum A-00-71 provides examples of post-surgical cases where the condition that led to the surgery is coded (because V-codes are not allowed). The same logic applies to post surgical-wound care because, other than V-codes, there are no diagnosis codes for uncomplicated surgical wounds).

Part B of question: In another case with a patient with a BKA you said to list the open wound as the primary diagnosis instead of the underlying disease of Diabetes? Can you please clarify which primary diagnosis is correct? The Volume 1, Batch 2 Question is a two part question: (part a) asked if surgical incisions can be coded using trauma codes, our response was no, " Care for surgical incisions is Not coded with a trauma code."; (part b) asked if a surgical code could be used as a secondary diagnosis code as well as underlying diagnosis in documentation which we assumed to be in the OASIS, our response was as follows: "OASIS does not allow surgical codes (which are not diagnosis codes) or V-codes. V-codes would be the most

appropriate in these cases, but cannot be used on OASIS. Currently, OASIS instructions for surgical wound cases are to code the underlying or medically relevant diagnosis."

You did not specify the specific location of the BKA question that you are referring to however we assume you are referring to Volume 3, March 2001-Batch 1 question which is a question related to the coding of an amputation wound from a non-traumatic amputation in which the wound is not complicated. Our response to this question was to clarify the correct utilization of amputation codes when treating a surgical amputation wound. We provided the following response: "One would not use the amputation codes for treatment of a home care patient after a surgical amputation. The amputation codes would only be appropriate in the case of an accidental amputation. Note that if a diabetic patient is primarily receiving home health therapy for an abnormality of gait due to a below-knee amputation, the code for abnormality of gait may be the most accurate primary diagnosis. The patient is now missing a leg, and the abnormality of gait may best describe the primary reason for home care (a missing leg)".

In the response to both of the above previous questions, we explained that the reason/disease /condition that necessitated the surgery should be coded. However in the amputation question we added further clarification as to when the amputation codes from the injury chapter of the ICD-9-CM could and could not be used.